FUNDS DISBURSEMENT REQUEST FORM

Funds Disbursement Request # _1_____ **Grant #:** __06-4-C-4892_____

Date: __November 28, 2003_____

Amount Requested $ 200,000

Identify, by work activity, all work completed for which payment is requested. Provide evidence of completion of work identified. Also complete a Financial Report Form and a summary page of expenses that reference the invoices and back-up information included.

Sitka Community Hospital participated in a competitive bidding process that resulted in the acquisition of a Philip's HDI 5000 ultrasound machine and accessories. The total cost, including installation and training, is $210,203.00. The machine has been received by the hospital and has been installed by service representatives from Philip's. Applications and advanced training on the machine is scheduled for the second week of December 2003. This will complete the acquisition/installation process.

A detailed invoice is attached that outlines all components of the acquisition.

You must attach a copy of invoice for which payment is requested, i.e. bill from contractor, subcontractor, materials supplier, or other party approved by DHSS.

If reimbursement is requested, provide evidence of prior payment by the Grantee.

Sitka Community Hospital has not paid for any portion of this acquisition, to date.

I certify that all evidence presented to the Department of Health and Social Services, is in accordance with this capital Grant is true and correct.

Philip D. Walsh, CASD
Signature

1-9-04
Date

FINANCIAL REPORT FORM

Name of Grantee: Sitka Community Hospital Grant Number: 06-4-C-4892

If submitting as part of a *Funds Disbursement Request*:
For work activities ending: December 2003
~~mm/dd/yyyy~~

BUDGET CATEGORY (ACTIVITY)	TOTAL FUNDS APPROVED	FUNDS EXPENDED THIS PERIOD	TOTAL FUNDS EXPENDED	FUNDS ADVANCED THIS PERIOD	TOTAL FUNDS ADVANCED
Ultrasound Purchase	$200,000	$210,203	$210,203		
Philip's HDI 5000					
PROJECT TOTALS	$200,000	$210,203	$210,203		
INTEREST EARNED THIS PERIOD					
TOTAL INTEREST EARNED					

I hereby certify that all of the information provided in this report is true and accurate and that all of the activities outlined in this report have been in accordance with Grant Agreement.

Signature & Title of Authorized Representative: Philip R. Walker, CASC

Date: 1-9-04

Grant Progress

In addition to the information requested above please provide a brief narrative of all activities and work completed during the reporting period including applicable inspection and client service information. Use additional paper if necessary.

If this is the Final Report form to be submitted, please include the following:
Approximate number and type (*mental illness, developmental disabilities, chronic alcoholics with psychosis, or Alzheimer's disease with related dementia*) of Mental Health Trust beneficiaries served by this project.

NOTE: Number of beneficiaries served is based on a 12 month period ending June 30th. Repeat visits by the same beneficiary is considered one beneficiary served.